Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NSG	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S 000	Initial Comments COMPLAINT INVESTIGATION 23910070/IL167393 2399414/IL166580 2399570/IL166768 2399137/IL166232	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.1610a)1) 300.1620a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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S9999	Continued From page 2 Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to follow their practice to confirm and follow physician orders to monitor blood glucose and administer insulin per sliding	S9999		

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S9999	Continued From page 3 scale as prescribed for a resident diagnosed with type 2 diabetes with hyperglycemia. This affected one of three (R8) residents reviewed for physician orders. This failure resulted in 13 missed opportunities for blood sugar checks and 13 opportunities for insulin administration, R8 was sent to hospital, evaluated and treated for diabetic ketoacidosis, R8's blood glucose 658mg/dl. Findings include: R8's face sheet shows diagnosis of type 2 diabetes mellitus with hyperglycemia. On 12/8/23 at 10:23 pm, V19 (R8 family) said when she visited R8 on 11/16/23 around 11:30am-11:45am, R8 was observed in the dining room slumped over in his wheelchair, V19 said she called out to R8 and R8 replied "help me" V19 said she informed the nurse of R8's condition. V19 said the Nurse checked R8's blood sugar and she informed her that it was reading "high". V19 said the facility gave R8, 8 units of insulin a couple of times but the reading remained high. V19 said while in the hospital R8's blood sugar was over 600 mg/dl. V19 said when R8 recovered days later R8 told her he was not getting his insulin like he should have been. On 12/8/23 at 12:20 pm V20 (LPN) said she was informed that R8 was in the dining room and R8 was experiencing a change in condition. V20 said she checked R8's blood glucose at that time and it was reading high. V20 said she had not check R8's blood sugar prior to the change in condition, she did not administrator insulin prior to the change in condition. V20 said she did not check R8's blood sugar that morning before breakfast, she did not administrator insulin to R8 before	S9999		

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breakfast. V20 said she does not know if R8 is a type 2 diabetic or type 1 diabetic. V20 said she just follows the orders on the M.A.R- (medication administration record). V20 said if there was not an order for blood glucose monitoring then she did not check R8's blood sugar. Follow up interview with V20, V20 said she administered R8 insulin on 11/16/23 from an insulin pen that R8 had from a previous insulin order.

On 12/8/23 at 11:27 am, V9 (Director of Nursing) said R8's Humalog insulin had not arrived at the facility by 11/16/23. V9 said the order was pending in the electronic system. V9 explained that the pharmacy has authority to change a medication as appropriate, V9 said that's a therapeutic interchange. V9 said the original medication will be discontinued and the new medication would be started, pharmacy will enter the order. V9 said the nurses are supposed to check for pending orders and confirm orders so that the pharmacy can send the medication. V9 said she was made aware on 11/16/23 that R8 was having a change in condition and so she checked R8's orders. V9 said she noticed that R8 had a pending order for Humalog insulin. V9 said she confirmed the order on 11/16/23 as R8 was being transferred to the hospital for the change in condition. V9 said R8's Humalog had not arrived before he was sent to the hospital. V9 said she checked the electronic records and there are no blood glucose results for R8 outside of 11/10/23 date. V9 said the nurse should check the blood glucose level before administering insulin. V9 said the blood glucose results are attached to the insulin orders. V9 said the nurse should follow the physician orders for monitoring the blood glucose levels. V9 was asked how the facility ensures that the resident with diabetes mellitus continue to receive blood glucose monitoring when the insulin

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order is in a pending status. V9 said the policy for blood glucose must be reviewed, V9 said she can't answer that. V9 said assessing the blood glucose is basic nursing practice, the nurse should know to check the blood glucose before administering insulin. V9 was asked if R8 received blood glucose monitoring before being given insulin at nighttime. V9 restated that she cannot find any blood glucose results outside of the 11/10/23 date. V9 presents glucometer used by facility, V9 said the glucometers will give blood glucose up to 600 mg/dl (milligrams/decaliters). V9 said any blood glucose results after 600mg/dl will read "hi" on the glucometer. V9 said the nurses have been in-serviced on checking the electronic records for pending orders. V9 omitted if staff was in-serviced /trained on monitoring the blood glucose for diabetic residents when the blood glucose order are in pending status with the insulin orders. V9 continued to say assessing blood glucose is basic nursing practice. V9 explained that the letters "BS" noted on the MAR refers to blood glucose results, V9 said to administer insulin sliding scale the nurse must check the blood glucose. V9 explained that the blood glucose results should be documented to the MAR and signed off by the nurse that checked the blood glucose and administered the insulin. V9 said the pending order is an active order.

On 12/12/23 at 2:12 pm, V22 (Medical Doctor) said he was not aware that R8 missed 13 opportunities for accu-checks and 13 opportunities for insulin administration. V22 said he was not aware that R8's blood glucose was reading was over 600mg/dl. V22 said the facility informed him today (12/12/23) of the situation. V22 said he does have a Nurse Practitioner that sees his residents and that the NP sent R8 out to

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hospital on 11/16/23, but she should have informed him. V22 said R8 is diabetic and should have his blood glucose monitored before meals, and R8 should be administered insulin per sliding scale. V22 said the blood glucose monitoring order and insulin order should not be attached together, V22 said there should be 2 orders. V22 said there should be 2 orders to ensure that the blood glucose is continued to be monitored. V22 said the facility needs to correct this. V22 said R8 did not need blood glucose monitoring for the 9:00 pm insulin but R8 did need to have his blood sugar monitored before meals. V22 said the nurse should have notice that R8 was not receiving accu-checks before 11/11/23- 11/16/23.

On 12/12/23 at 2:46 PM, V24 (Pharmacy Rep) said R8's insulin was delivered to the facility on 11/11/23 at 12:30 according to his report.

On 12/12/23 at 3:04 PM during observation tour of medication room on second floor with V23 (LPN), there was 2 insulin pens to be returned to pharmacy labeled with R8's name, dated 11/10/23, one pen was labeled Humalog, and the other pen was labeled Novolin. V23 said those medications were removed from the medication cart and will be returned to pharmacy. V9 (DON-Director of Nursing) arrived at the unit to observe insulin pens for R8 that remained in facility on 12/12/23. V9 said she can see that R8 has insulin pens, and they are to be returned to pharmacy. V9 reviewed the label on the pens and verified date of 11/10/23, V9 verified there was medication inside both insulin pens, V9 said she does not know how much medication is inside the Humalog insulin pen. V9 said the Novolin insulin pen had 250 units of insulin inside.

R8's progress notes dated 11-16-23 completed by

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nurse practitioner, denotes lethargic, change in mental status, HPI: R8 is a 67-year-old male seen today at the request of nursing due to change in condition, including lethargy, hyperglycemia. Resident seen lying in bed. Nursing reports that he slumped over in the dining room. He was found to have blood glucose reporting high on the glucometer and taken to his room. His wife had come to have lunch with him and was at his bedside. Nurse had administered 8 units of lispro before lunch. Resident did not eat lunch, ordered 8 more units of lispro. BP 99/59, HR 56, T 96.6F, SpO2 95% RA. BGM (blood glucose monitoring) 15 minutes later was still high on glucometer. Ordered administration of an additional 8 units lispro. Resident was alert and oriented x2. Reporting abdominal pain, discomfort, asking for help, stating his sugar was high. Resident not answering questions, anxious facial expression. Resident had facial symmetry, however, left side flaccid. About 10 minutes, resident raised hand to his wife, previous flaccidity may have been attributed to not following instructions, still ambulance was made aware of possible stroke alert. Per wife, resident had a TIA during his last episode of severe hyperglycemia. Writer and nursing management with resident until EMTs arrived. Resident was transported to the ED.

R8's physician order sheet dated 11/11/23 denotes orders for Humalog Kwik pen 100 units/ML (milliliters) solution pen injector, inject as per sliding scale: if 120-150=3 units, 151-200=6 units, 201-250= 9 units, 251-350=12units, subcutaneously before meals related to type 2 diabetes mellitus with hyperglycemia. Novolin N subcutaneous suspension 100 unit/ ML (insulin NPH (human) (isopheal) inject 12 units subcutaneously at bedtime for diabetes.

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S9999	Continued From page 8 Review of R8's (MAR- medication administration record) dated 11/11/23 at 4:00 pm, there is no blood sugar results or initials by staff denoting blood glucose was completed or insulin was administrated. 11/12/23 at 7:30am, 11:00am, and 4:00pm there is no blood sugar results or initials by staff denoting blood glucose was completed or insulin was administrated. 11/13/23 at 7:30am, 11:00am, and 4:00pm there is no blood sugar results or initials by staff denoting blood glucose was completed or insulin was administrated. 11/14/23 at 730am, 11:00am, and 400pm there is no blood sugar results or initials by staff denoting blood glucose was completed or insulin was administrated. 11/15/23 at 7:30am, 11:00am, and 4:00pm there is no blood sugar results or initials by staff denoting blood glucose was completed or insulin was administrated. 11/16/23 at 7:30am, and 11:00am there is no blood sugar results or initials by staff denoting blood glucose was completed or insulin was administrated. The facility missed 13 opportunities out of 13 opportunities to monitor R8 blood sugar and administrator insulin as prescribed between the dates 11/11/23 through 11/16/23. R8's emergency room records dated 11/16/23 denotes in-part R8, 67-year-old male past medical history on dialysis, CVA, DM, L tibia fracture, presents to ED via EMS from nursing home for altered mental status. Wife found patient at noon with altered mental status, ambulance was not called by, and mark for over an hour, reason unknown. Per EMS he was very hyperglycemic with readings "high" s/p (status post) 10 units prior to arrival and remains hypotensive s/p 500 bolus in transit. He was not given insulin today prior to incident. Comprehensive metabolic panel denotes in-part	S9999		

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S9999	Continued From page 9 glucose results 658mg/dl, reference range is 70-99 mg/dl. Active problem list denotes in-part diabetic ketoacidosis. Facility physician order policy, no date noted denotes in-part it is the policy of the facility to follow orders of the physician. At the time of admission, the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the residents mental and physical admission. Facility policy titled Blood Glucose Monitoring no dated noted, denotes in part it is the facility policy to ensure that residents who require blood sugar monitoring due to hyperglycemia or hypoglycemia secondary to diabetes or for any reason deemed necessary by the physician receives this monitoring. All glucose monitoring will be ordered at the direction of the resident's physician except in emergency situations. High and low parameters will be determined by the physician to maintain residents blood sugar within normal limits. Blood sugar found to be below 70 or above 400 will be reported immediately to the physician and the resident's representative. Any orders received from the physician will be implemented. Explain procedures to resident, clean finger, perform finger stick, place blood on accu-check strip and obtain a reading, record accu-check reading on the facility blood glucose monitoring tool, administer insulin to include sliding scale insulin per physician order. (A) Statement of Licensure Violations (2 of 2) 300.610a)	S9999		

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S9999	Continued From page 10 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the	S9999		

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S9999	Continued From page 11 resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met evidenced by: Based on observation, interview and record review the facility failed to have an effective policy for contraband material to ensure that contraband is not brought into the facility. This affected two of two residents (R5 and R15), this failure resulted in R5 found unresponsive sent to hospital, tested positive for opioids on 9/6/23 and 10/31/23, R15 sent to hospital for chest pain and diagnosis with	S9999		

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S9999	Continued From page 12 marijuana use. Findings include: 1. On 12/6/23 at 11:35 am, R5 observed alert to person, place, time and situation. R5 said on 9/6/23 he got heroin from someone in the facility, then R5 said he received heroin from someone that delivered the drugs to him. R5 said he was outside the front of the facility and someone in a car pulled up and dropped it off to him. R5 said he took too much heroin that day he overdosed. R5 would not say if he received deliveries of street drugs on any other day. V9 (Administrator) made aware of R5 alleged he got heroin from someone in the facility, then stating he got heroin from someone outside the facility. On 12/14/23 at 12:12 pm, V25 (Assistant Director of Nursing) said on 9/6/23 R5 was found on the first floor unresponsive, R5 was given Narcan and responded to the Narcan, 911 was called, escorted R5 to hospital and R5 returned with diagnosis of drug overdose. V25 said she does not know where R5 retrieved the drugs from. V25 said R5 was readmitted back to the facility the same night. On 12/14/23 at 12:19 pm, V11 (social services) said on 9/6/23 he saw R5 prior to R5 being found unresponsive outside visiting with someone in a black vehicle. V11 said about an hour later there was a code blue announcement for R5. V11 said he did not see anything in R5 hand when R5 return to the facility. V11 omitted to searching R5 upon return to the facility. V11 said R5 will not tell him or staff in the facility where he retrieved the drugs from. V11 said the resident's food and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S9999	Continued From page 13 packages are opened in front of the staff. R5's hospital records dated 9/6/23 denotes in-part R5 is a 32-year-old male who presents today for concerns for a drug overdose. Urine drug screen positive for amphetamine, and opiates. R5 progress notes dated 10/31/23 denotes in-part contacted hospital to inquire on residents' status, resident admitted to room xx with opioid overdose accidental or intentional. 2. On 12/13/23 at 11:58 am, R15 observed alert to person, place, time and situation. R15 said he had a seizure on 10/18/23, he doesn't know about using marijuana. R15's progress notes dated 10/18/23 denotes resident went out via ambulance x4 assist to hospital. Resident stable and alert. Resident complains of chest pain and n/v (nausea/ vomiting). Vitals b/p=110/76 O2=98 pulse=69 temp=98.1. Resident reports pain level of 4. Writer spoke with MD (medical doctor). MD ordered to send resident out to hospital. Orders carried out. Writer spoke with sister. Sister satisfied transfer. DON (director of nursing) made aware. ADON (Assistant Director of nursing) made aware. No s/s of distress noted. Bed hold policy in place. Resident returned from hospital via stretcher per ambulance service. Accompanied x 2 attendants. Alert and oriented x 2-3. DX (diagnosis) marijuana use, Vomiting. No C/O chest pain. T 98.6 p76 R 18 b/p 130/78 pulse ox 98% to room air. Family made aware DON (Director of Nursing) made aware. On 12/13/23 at 11:07am V9 (Director of Nursing) said R15 did not have an independent pass privilege on 10/18/23, V9 said she does not know where R15 retrieved the marijuana from.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 On 12/14/23 at 12:19 pm, V11 (social services) said he does not know where R15 retrieved marijuana from, V11 said R15 won't tell him when asked. Review of R15 physician order sheet, there is no orders noted for use of marijuana. Facility policy titled contraband material, no date noted, denotes the facility reserves the right to check individuals and conduct room inspections if there is reason to believe resident or visitors are harboring contraband materials. Contraband material includes, but not limited to alcohol, illicit or street drugs, weapons including any sharp objects, smoking material (if a resident is a safety risk). Rooms may also be searched for lost or stolen property. These processes will only occur when the administrator, director of nursing or mental health practitioner suspects a resident or residents are harboring contraband materials. The search of an individual or rooms will be conducted with privacy and dignity. (B)	S9999		